Medwork Independent Review
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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION
WORKERS' COMPENSATION - WC

DATE OF REVIEW: 10/13/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Right L3-L4, L4-L5, L5-S1 transforaminal epidural steroid injection.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Texas State Licensed MD Board Orthopedic Surgeon

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)
Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY:
The submitted records were reviewed included the documentation from the provider's clinical records. It was noted that the individual was reportedly injured on xx/xx/xx. It was noted that the individual had persistent low back pain with radiation to the right lower extremity including down to at least the level of the thigh. Paresthesias were also noted into the right lower extremity. The condition was noted to have been associated most recently on May 12, 2015 with limited lumbar motion that was painful along with some tenderness. There was no documentation of the objective neurologic examination on that date. Treatments were noted to have included NSAIDs along with the course of physical therapy. The physical therapy records from select Physical Therapists from the summer of 2015 were reviewed. Diagnoses were noted to include lumbar sprain and lumbago and degeneration of lumbar intervertebral discs. The injury mechanism in itself was noted on 05/12/2015 in the provider records to have been that the then was noted to have been bending, "pulling a shake table and got pulled by table and hurt his back after." The findings were noted in that particular record to occlude that pain radiated to the "right dorsal foot." The "cause of the sciatica is a herniated disc." It was noted by the provider revealed diagnoses of lumbar DJD and herniated disc and radiculopathy. Medications were noted to be multiple as documented.

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ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The documentation does not evidence objective findings of clinical radiculopathy on the patient's lower extremities. The findings appeared to be radicular in nature. However, do not need guideline criteria for the proposed transforaminal epidural steroid injections. Guideline criteria typically include objective clinical examination findings of radiculopathy which are not documented to be present in the record provided.

In addition, guidelines from the referenced ODG low back chapter and criteria for use of epidural steroid injections do not support injections at more than 2 levels. In this case, therefore, the proposed 3-level transforaminal epidural steroid injections are not considered medically reasonable and necessary as the ODG criteria low back, epidural steroid section has not been met as referenced below.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**